PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 04/04/2	LETED
NAME OF PROVIDER OR SUPPLIER			I	ADDRESS, CITY, STATE, ZIP COE PIKE AVE	DE .	
GOLDEN	I LIVING CENTER-	PETERSBURG	I	RSBURG, IN47567		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0000	1	or a Post Survey Revisit	F0000			
		certification and State				
	Licensure Surve	ey completed on 2/14/11.				
	Survey Date: A	pril 4, 2011				
	 Facility Number	·· 000033				
	Provider Numbe					
	AIM Number: 1	100266280				
	Survey Team:					
	Martha Saull, RN					
	Carole McDaniel, RN					
	Terri Walters, RN					
	Liz Harper, RN					
	Census Bed Type:					
	SNF/NF: 54	c.				
	Total: 54					
	Census Payor Ty	ype:				
	Medicare: 2					
	Medicaid: 46					
	Other: 6					
	Total: 54					
	Sample: 10					
	Golden Living C	Center-Petersburg was				
	1	ubstantial compliance with				
	42 CFR Part 483	Subpart B in regard to				
	the PSR to the Recertification and State					
	Licensure Surve	y.				
	This deficiency	also reflects state findings				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIC		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G04E12

Facility ID:

000033

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00		COMPLETED		
		155375	B. WIN			04/04/2	2011
	PROVIDER OR SUPPLIER N LIVING CENTER-			309 W PETER	ADDRESS, CITY, STATE, ZIP CODE PIKE AVE SBURG, IN47567		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)		DATE
		nce with 410 IAC 16.2.					

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Event ID:

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Facility ID: 000033

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING B. WING		00	COMPLETED
		155375				04/04/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					PIKE AVE	
	I LIVING CENTER-F	PETERSBURG			RSBURG, IN47567	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0363		ation, interview and	F036	53	The corrective actions accomplished for those residents	04/05/2011
SS=A		e facility failed to ensure		found to have been affected		
	menus were follo	owed for concentrated			deficient practice are as follows:	
	carbohydrate die	ts for 3 of 6 residents				
	reviewed for mer	nu accuracy in a sample			On April 5, 2011 received new die	
	of 10.				orders from physicians for residen	its
	Resident #1, Res	ident #2, Resident #3			#1, #2, #3 to receive regular	
					desserts. A facility wide audit wa completed April 5, 2011 on all	S
	Findings include	d:			Con-Cho diet orders to ensure	
	<i>J. J. J</i>				facility was following the diet	
	On 4/04/11 at 11:	50 A.M. the noon meal			orders. No other deficiencies wer	e
	was observed to be served in the ACU (Alzheimer's Care Unit.) CNA# 1 identified three residents who were diabetics. The three identified Residents, #1, #2, and #3, were each			found.	found.	
					Other residents having the	
					potential to be affected by the	
					same deficient practice will be identified and corrective actions	
					taken are as follows:	
	identified and observed to be served and					
	ate the same dessert as the residents on regular diets, which was a scoop of ice				In-Service was completed 3/3/11 to	
					all cooks and diet aides on following	- 1
		rie and the same meatloaf			menus and spreadsheets as writter	1,
	portion with mea	t loaf sauce.			specific to portion control and therapeutics diets. The DSM will	
					monitor daily (at least 5 times per	
	The facility sprea	nd sheet for the noon			week for 4 weeks) the tray line for	
	meal indicated re	sidents on Con-CHO			therapeutic diet compliance and	
	(Controlled Carb	ohydrate) diets were			following spreadsheets to the writ	ten
	menued to have a	pineapple for dessert and			menu. The DSM will check tray	
	no meatloaf sauce. The facility spread sheet was reviewed on 4/4/11 at 12:40 P.M.				tickets daily for completeness. The	
					Registered Dietitian during visits monitor for menu/spreadsheet	WIII
					compliance. In addition to the	
	1.171.				previous POC: Any new admission	on
	The clinical reco	rds of each of the three			or change in resident diet orders o	
	The clinical records of each of the three residents were reviewed on 4/04/11				Con-Cho diets will be reviewed in	
		M. and 12:30 P.M.			Clinical Start up daily to ensure w	
					are meet the nutritional needs of the	he
	Resident #2 had diagnoses including, but				resident. All residents physician	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPLETED		
	155375		B. WIN			04/04/2011	
NAME OF BROWINGS OF GUIDNI IED				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				309 W PIKE AVE			
GOLDEN LIVING CENTER-PETERSBURG					RSBURG, IN47567		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	1	LSC IDENTIFYING INFORMATION)	+	TAG	1 11 /	DATE	
	not limited to, "D				ordered diet orders will be reviewed weekly by the Dietary Service	ed	
	1 1	e II instability not stated			Manager from computer generated	.	
	uncontrolled" and	d a physician order dated			report and compared to dietary tra		
	2/4/11 for a regul	lar diet with Con-CHO			tickets.	,	
	dessert.				denets.		
ı					What measures will be put into		
	Resident #1 had	diagnoses including, but			place and the systemic changes		
		0			made to ensure that this deficien	t	
	not limited to, "D				practice does not recur are as		
	1 ^ -	pe I JUV (juvenile) not			follows:		
	stated uncontrolled" and a physician order dated 2/4/11 for a regular diet with Con-CHO dessert. Resident #3 had diagnoses including, but not limited to, "Diabetes without						
					The Dietary Service Manager will		
					monitor daily (at least 5 times per		
					week for 4 weeks) the tray line for therapeutic diet compliance and		
					following spreadsheets to the writ	ten	
					menu. The DSM will check tray	ich	
					tickets daily for completeness. Th	ie	
	1 1	e II instability not stated			Registered Dietitian during visits		
	uncontrolled" and a physician order on				monitor for menu-spreadsheet		
		ar diet with Con-CHO			compliance. In addition to the		
	dessert.				previous POC: Any new admissi	on	
					or change in resident diet orders o		
	On 4/4/11 at 12:5	50 P.M., the ACU			Con-Cho diets will be reviewed in		
	Director and Cha	irge Nurse LPN #1 were			Clinical Start up daily to ensure w		
		indicated residents who			are meeting the nutritional needs of		
	· ·	he unit were to be served			the resident. All Residents physici		
					ordered diet orders will be reviewed weekly by the Dietary Services	ea	
	me same dessert	in a smaller portion.			Manager from computer generated	,	
	On 4/4/11 at 1:00 P.M. the Food Service Manager indicated, when informed of the				report and compared to dietary tra		
					tickets. The Dietary Services	,	
					Manager or designee will monitor	5	
	problem, the resi	dents were to have			times weekly for 4 weeks for		
	received pineapple and she had noted three extra pineapple desserts in the				therapeutic diet compliance.		
					Following 4 weeks, the Dietary		
		• •			Designee will monitor 3 times		
	kitchen and thought the kitchen staff who were serving "did not realize."				weekly for an additional 4 weeks	for	
	were serving and	i not reanze.			therapeutic diet compliance. The		
						1	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155375		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/04/2011				
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN47567					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	2/14/11. The fac	ciency was cited on cility failed to implement of correction to prevent		DSM will review the therapeutic diets for the menu with the dining staff at the daily production meetings. The DSM will in-servidining staff at least bi-annually of therapeutic diets.	ice			
				How will these corrective action be monitored to ensure the deficient practice does not recur				
				The DSM will monitor daily (at I 5 times weekly for 4 weeks) the t line for therapeutic diet complian and following spreadsheets to the written menu. The DSM will che tray tickets daily for completenes. The Registered Dietitian during will monitor for menu-spreadshec compliance. The Dietary Service Manager will report trends of deficient practice to QAA Comm on a monthly basis for continued recommendations and resolutions 3 months then quarterly times two. In addition to the previous POC Any new admission or change in resident diet orders on Con-Cho or the previous process of the previous process.	ray ce cck s. isits et ss iittee for o. i:			
				will be reviewed in Clinical Start daily to ensure we are meeting th nutritional needs of the resident. residents physician ordered diet orders will be reviewed weekly be the DSM from computer generate report and compared to dietary trickets. The Dietary Services Manager or designee will monito times weekly for 4 weeks for therapeutic diet compliance.	e All y ed ay			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	(X2) M A. BUI B. WIN	LDING G	ONSTRUCTION 00	(X3) DATE COMPI 04/04/2	LETED
GOLDEN	PROVIDER OR SUPPLIE	-PETERSBURG		309 W PETER	ADDRESS, CITY, STATE, ZIP CODE PIKE AVE ASBURG, IN47567		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY		THOTNAL	DATE
					Following 4 weeks, the DSM/designee will monitor 3 tim weekly for an additional 4 weeks therapeutic diet compliance. The DSM/designee will review the therapeutic diets for the menu wit the dining staff at the daily production meetings. The DSM/designee will in-service dir staff at least bi-annually on therapeutic diets. This will be reviewed to QA&A committee on a monthly basis for continued monitoring for three months then quarterly times two.	for th ning	

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